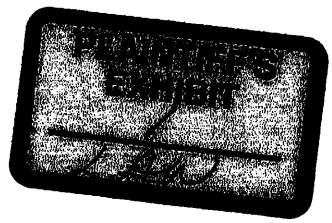
EXHIBIT 5
EXHIBITS TO THE DEPOSITION OF DR. VINCENT LAW

ICU

RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED REC #: M0124352
STATUS: ADM IN



HISTORY/PHYSICAL EXAMINATION

DATE OF ADMISSION: 01/16/04

CHIEF COMPLAINT: Fatigue, malaise, rash.

HISTORY OF PRESENT ILLNESS: Mr. Kelley is a 32 year old white male with a history of alcohol abuse, chronic low back pain, history of migraine headaches who was recently discharged from jail earlier today who presented complaining of fatigue, malaise, increased confusion and increased yellowish discoloration of his skin. In addition he reported increased abdominal girth. He reports that his symptoms have been ongoing over the past 4-5 weeks but has been recently. He has not had any vomiting, diarrhea, constipation. He has noted that his urine has been darker than usual. He was incarcerated for approximately 2 1/2 months and apparently there has been some type of confusion in terms of his medications for his back pain and his bipolar disorder. He apparently had been receiving up to 3-4 times higher dose of Zyprexa, Neurontin, Klonopin, Seroquel and Robaxin, however, the patient is somewhat confused about his medications and his story is somewhat inconsistent at different points during the interview.

PAST MEDICAL HISTORY: As above. He has been diagnosed with bipolar disorder by two different psychiatrist.

PAST SURGICAL HISTORY: Remarkable for artificial L1-L2, and S1 secondary to previous low back fractures. He has had bilateral knee arthroscopies.

ALLERGIES: Codeine causes a rash and hallucinations.

MEDICATIONS AT HOME INCLUDE:
1. Zyprexa 20 mg that he was receiving in jail. He reported that he was only taking 5 mg at bedtime.
2. Neurontin 300 mg one po t.i.d. which was given to him jail but he also reported that he was just taking it once a day.
3. Klonopin 2 mg one po q hs, he had been getting the Klonopin one po b.i.d.
4. Phenobarbital 60 mg b.i.d. which he was receiving in jail but he was not taking Phenobarbital prior to his incarceration.
5. Seroquel 200 mg one po b.i.d. given 1 po t.i.d. while incarcerated.
6. Robaxin 750 mg one po b.i.d. which he had been taking prior but again was given two po b.i.d. while incarcerated.

SOCIAL HISTORY: No recent tobacco use in the past three months. No recent alcohol use, as mentioned above he has been incarcerated over the past 2 1/2 months. He has been in drug rehab. He denies any history of illicit drug use. He is currently divorced.

FAMILY HISTORY: Remarkable for alcoholism and cirrhosis secondary to alcohol abuse. Also history of coronary artery disease. No known history of diabetes mellitus or cancer.

RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED REC #: M0124352
STATUS: ADM IN

HISTORY/PHYSICAL EXAMINATION

REVIEW OF SYSTEMS:
He has had some marked weight increase, approximately 20 lbs over the past 1-2 months. He also has had some frequent dyspepsia but no nausea or vomiting or hematemesis. No history of melena or hematochezia. No chest pain or acute shortness of breath. No fever or productive cough. He has noted that his urine has been darker than usual. He also has noticed a mild swelling in both his feet.

PHYSICAL EXAM:
VITAL SIGNS: Temp. 98.2, heart rate 101, respiratory rate 18, blood pressure 124/70.
GENERAL: This is a well-developed, well-nourished white male currently in no apparent distress, awake, alert and oriented X 3. He appears extremely icteric.
SKIN: No rash.
HEENT: Pupils equally round and reactive. Sclerae icteric. Extraocular movements intact. Nasal oropharynx clear.
NECK: Is supple with no JVD, lymphadenopathy, carotid bruits or thyroid nodules.
LUNGS: Clear to auscultation with bilateral breath sounds.
CARDIOVASCULAR: Regular rate and rhythm without murmurs, gallops or rubs.
ABDOMEN: Protuberant with noted positive fluid wave test. No hepatosplenomegaly could be appreciated.
GU/RECTAL: Exams deferred.
EXTREMITIES: No clubbing, cyanosis, or edema. No calf tenderness or palpable lower extremity cords.
NEUROLOGIC: Cranial nerves II-XII grossly normal. No gross focal motor deficits there is noted asterixis of the hands. There is also noted mild clonus of the ankles bilaterally.

LABS: Upon admission; PT INR is 1.5, chemistry profile remarkable for BUN 5, Creatinine 1. LFTs elevated with total bilirubin of 7.9. AST of 1443, ALT 3425, alk/phos 241, ammonia level was slightly elevated at 37, TSH was normal. Glucose was normal at 88. CBC revealed a white count of 4.7 with H&H of 14 and 41 respectively. Platelet count of 383,000 with no left shift. Urinalysis was unremarkable except for 3+ bilirubin, no WBCs or bacteria.

ASSESSMENT AND PLAN:
1. Hepatic encephalopathy.
2. Hepatitis of unclear etiology, suspect secondary to multiple medications.
3. History of alcohol abuse.
4. Chronic lower back pain.
5. History of migraine headache.
6. Bipolar disorder.

Admit to ICU. Hold all of his medications for now. Continue serial neurochecks. Strict I&Os, GI consultation, check urine drug screen and Acetaminophen levels. Follow his LFTs. Will hold IV fluids for now as he is hemodynamically stable and his mental status is stable. Will consider IV Mannitol with deterioration of his mental status.

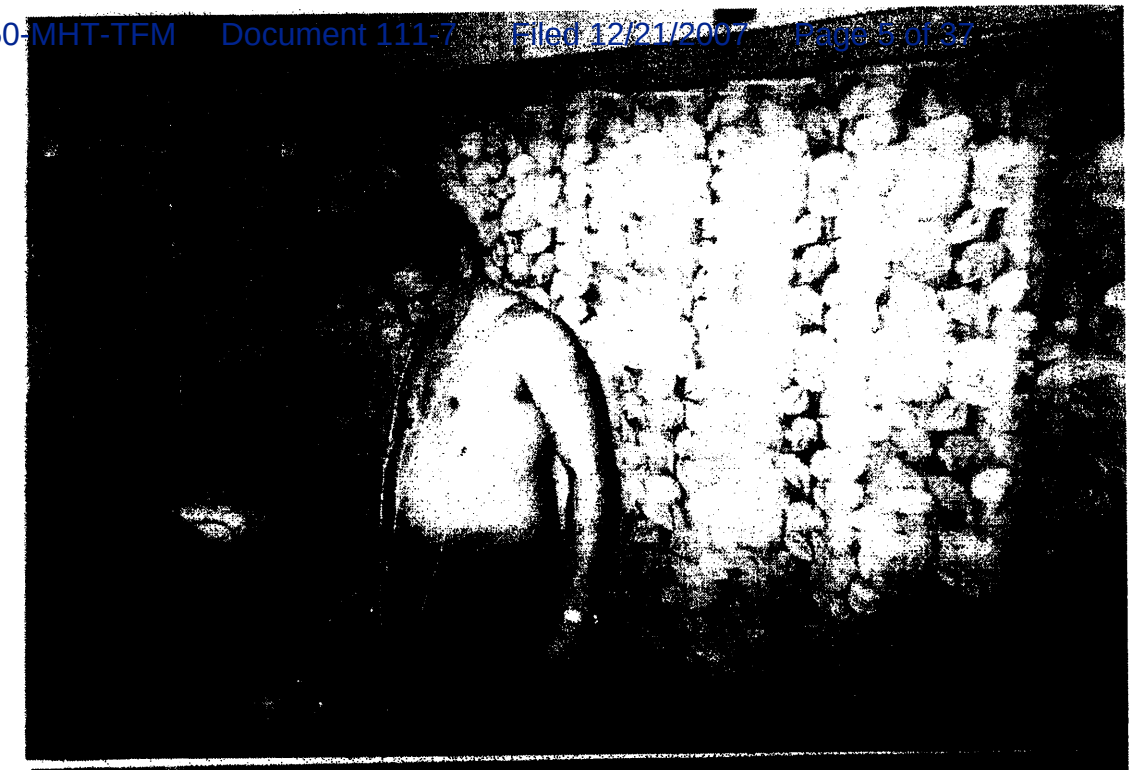
RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

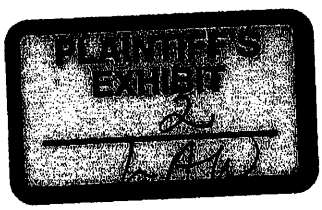
PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED REC #: M0124352
STATUS: ADM IN

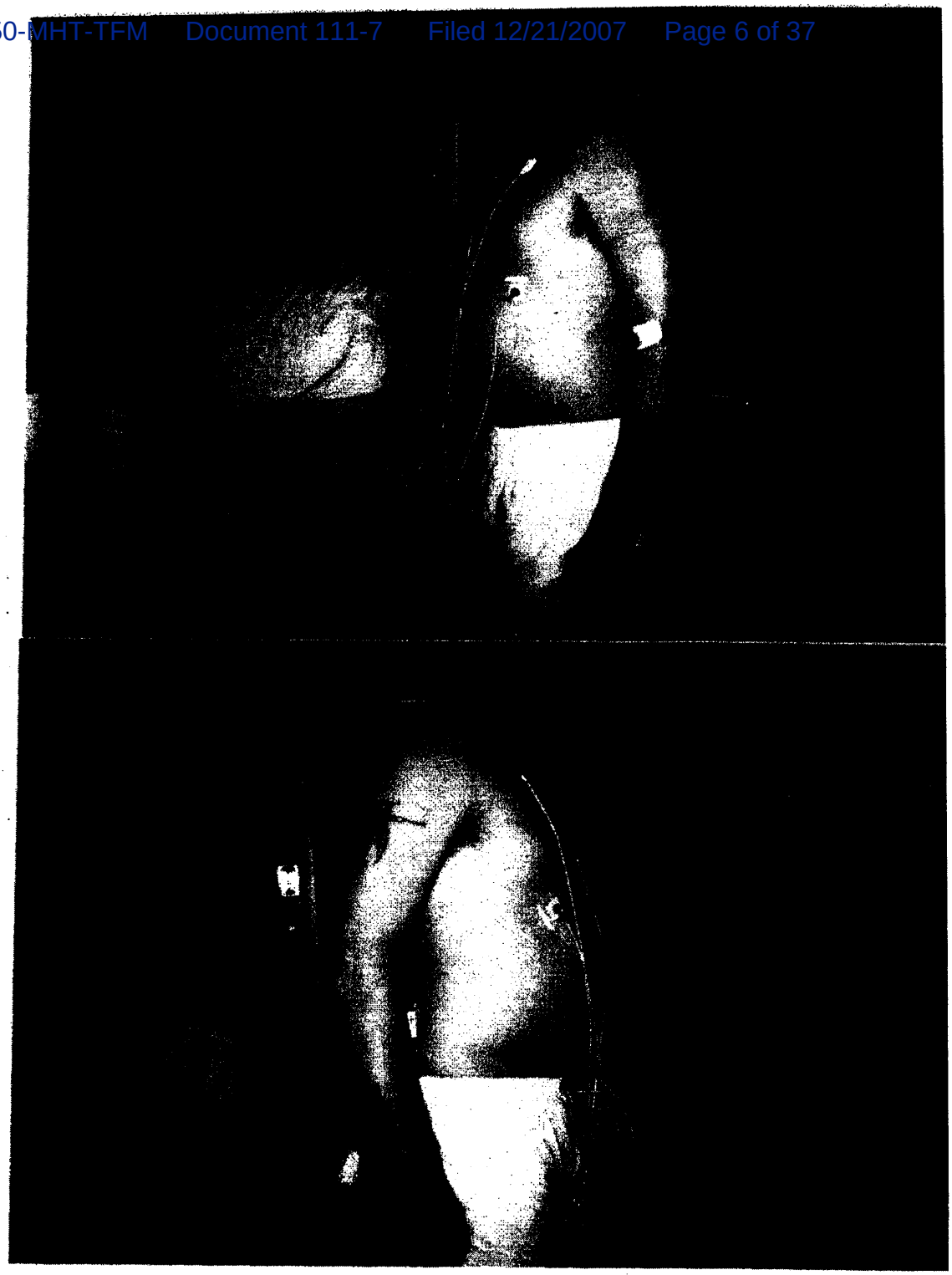
HISTORY/PHYSICAL EXAMINATION

Vincent Law, M.D.

VL/pp
D: 01/16/04 1942
T: 01/17/04 0611




PLAINTIFF'S
EXHIBIT



RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Holcombe,Derek K.
MED REC #: M0124352
STATUS: DIS IN

CONSULTATION REPORT

DATE OF CONSULTATION: 01/18/04

DIAGNOSIS: Acute hepatitis - etiology unclear, possibly drug induced.

HISTORY OF PRESENT ILLNESS: Mr. Kelley is a 32 year old male with a history of alcohol and drug abuse. He also suffers from bipolar disorder. He presented to Russell Medical Center with lethargy and what was felt to be hepatic encephalopathy. He was also found to have significant liver enzyme abnormalities and new onset jaundice. He does note vague bloating and upper abdominal pain. He has noted dark urine for the last week. He denies Tylenol intake. He is not drinking alcohol at this time, in fact, he has been incarcerated.

PAST MEDICAL HISTORY: Bipolar disorder, as mentioned. He is followed by a gastroenterologist, Dr. Dickenson, in Birmingham.

SURGICAL HISTORY: Is remarkable for surgery on L1, S2, bilateral knee arthroscopies.

ALLERGIES: Codeine.

MEDICATIONS INCLUDED: Zyprexa, Neurontin, Klonopin, Phenobarb, Seroquel, Robaxin.

SOCIAL HISTORY: No alcohol since he has been incarcerated over the last two and one-half months. He has been in drug rehab. He is currently divorced.

FAMILY HISTORY:
Alcoholism, cirrhosis.

REVIEW OF SYSTEMS: See admission history and physical.

PHYSICAL EXAM:
VITAL SIGNS: Blood pressure is 126/72, heart rate is 92, respiratory rate is 18, he is afebrile.
GENERAL: He is a pleasant young male in no distress but obviously jaundiced. He is alert and cooperative. There is no asterixis. Sclera are icteric. Oropharynx is clear.
NECK: Supple.
LUNGS: Clear.
HEART: Regular rate and rhythm, no murmurs are noted.
ABDOMEN: Soft. Bowel sounds are normal. No masses noted. Liver span is 11 cm to percussion in the right midclavicular line.
EXTREMITIES: Without edema.

LABORATORY DATA:
INR 1.4, acetaminophen level less than 10, ALT 3425, AST 1443, total bili. 7.4, alk. phos. 241.

PLAINTIFF'S EXHIBIT 4

EMERGENCY DEPARTMENT
NURSING ASSESSMENT SHEET

V010558872 H0124352

ER ER
KELLEY, DANIEL B.
DR. WILLIAMS, K
01/16/2004 MEDICARE
32Y CA/M 06/17/1971
CODIENE

PERSONAL PHYSICIAN: _____ ER PHYSICIAN: _____
NOTIFIED ( ) BEEPED ( ) TIME _____ INT _____ NOTIFIED ( ) TIME _____ INT _____
RESPONDED ( ) TIME _____ RESPONDED ( ) TIME _____

PHYSICIAN ON CALL FOR UNATTACHED PATIENTS _____

TEMP 98.2 PULSE 101 RESP 18 B/P 124/70 WT _____ CHIEF COMPLAINT: c/o weakness - pt jaundiced - was seen by Dr. James recently & had abnormal liver enzymes 1-7-04? pt. somewhat slow to respond & slightly slurred speech. has been falling alot recently.

NURSE RQ TIME 1452

FAMILY NOTIFIED:
YES ( ) NO ( )
TIME _____
PERSON _____

POLICE NOTIFIED: in custody of county sheriff.
YES ( ) NO ( )
TIME _____
PERSON _____

SOCIAL SERV. NOTIFIED:
YES ( ) NO ( )
TIME _____
PERSON _____

CORONER NOTIFIED:
YES ( ) NO ( )
TIME _____
PERSON _____

ALLERGIES: NKDA (Codeine

CURRENT MEDICATIONS: See list attached

PRIORITY:
EMERGENT ( )
URGENT ( )
NONURGENT ( )

MODE OF ARRIVAL:
AMBULATORY ( )
PERSONAL VEHICLE ( )
WHEELCHAIR ( ) in custody of county sheriff
IN ARMS ( )
AMBULANCE ( )

TETANUS HX:
UTD ( )
UNKNOWN ( )

PEDIATRIC IMMUNIZATIONS:
UTD ( )
UNKNOWN ( )

TX PRIOR TO ARRIVAL:
NONE ( )
O2 ( )
BCLS ( )
ACLS ( )
IV ( )
BACKBOARD ( )
C-COLLAR ( )
SPLINT _____
BANDAGE _____

PAST MEDICAL HISTORY:
RENAL DZ ( )
HEART DZ ( )
SEIZURE ( ) back problems
HTN ( )
DIABETES ( )
COPD / ASTHSMA ( )
CANCER ( )
OTHER Bi polar

TIME	IV FLUIDS	AMOUNT	SITE	GAUGE	NURSE
1452	NS	KVO	RAC	22g	AC

CODES FOR MEDICATION ADMINISTRATION SITES:
A) LEFT HIP C) LEFT THIGH E) LEFT ARM G) LEFT ABD
B) RIGHT HIP D) RIGHT THIGH F) RIGHT ARM H) RIGHT ABD

TIME	T	P	R	B/P	Sa 02	MEDICATION / TREATMENTS	DOSE	ROUTE	SITE	NURSE	COMMENTS / PT RESPONSE
1452					99%						

MENTAL STATUS:
( ) ALERT
( ) ORIENTED
( ) DROWSY
( ) LETHARGIC
( ) DISORIENTED
( ) UNRESPONSIVE
( ) CONFUSED

STIMULUS RESPONSE:
( ) N/A
( ) VERBAL
( ) TOUCH
( ) PAIN
( ) NONE

HAND GRIPS:
( ) N/A
( ) EQUAL
( ) STRONG
( ) WEAK
( ) RIGHT
( ) LEFT

MOVEMENT:
( ) N/A
( ) VOLUNTARY
( ) INVOLUNTARY

PUPIL RESPONSE:
( ) N/A
( ) PERRLA sclera jaundiced
( ) SLUGGISH
( ) BRISK
( ) NONREACTIVE

MUCUS MEMBRANES:
( ) N/A
( ) MOIST
( ) DRY
SKIN TURGOR:
( ) N/A
( ) NORMAL
( ) DECREASED

SKIN:
( ) WARM
( ) HOT
( ) DRY
( ) COOL
( ) MOIST
( ) COLD
( ) CLAMY

COLOR:
( ) NORMAL
( ) FLUSHED
( ) PALE
( ) JAUNDICE
( ) CYANOTIC
( ) MOTTLED
( ) DUSKY

PULSE:
( ) REGULAR
( ) IRREGULAR
( ) WEAK
( ) ABSENT

RESPIRATION:
( ) ADEQUATE
( ) LABORED
( ) SHORT OF BREATH
( ) HYPERVENTILATING
( ) SHALLOW

BREATH SOUNDS:
( ) N/A
( ) BBS = CLEAR
( ) ADVENTITIOUS
( ) DIMINISHED
( ) ABSENT
LEFT ( ) RIGHT ( )

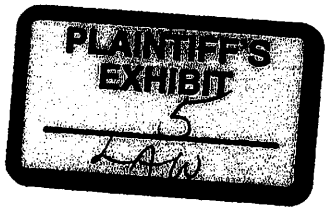
SPEECH:
( ) CLEAR
( ) COHERENT
( ) INCOHERENT
( ) SLURRED
( ) ABUSIVE

11127024

JEBOX 0789 Donna
EXANDER CITY, AL 35011-0789
one (256)234-4131

From 12/11/2003 To 08/03/2007

Statement Date	Last Patient Payment
8/3/2007	12/10/2004 Amt $0.00
Patient Name	**Account Number**
KELLEY,BRYAN,CCINMATE	F1D1E186168
Amount Due	**Amount Paid**
$0.00	$



Please send this portion with your payment

TE OF SERVICE 12/11/2003

YSICIAN	JOHN JOHN JAMES MD	PROCEDURE	INSURANCE		PATIENT	
OCEDURE	PROCEDURE DESCRIPTION	CHARGES	PAYMENTS	ADJUSTMENTS	PAYMENT	BALANCE
99212	OFFICE OUTPATIENT VISIT EST L2	$40.00				
	Jan 5 2004 payment from Coosa County Commissioner		$40.00			
	Jan 5 2004 adjustment from Coosa County Commissioner			$0.00		
J0702	INJ CELESTONE	$12.00				
	Jan 5 2004 payment from Coosa County Commissioner		$12.00			
	Jan 5 2004 adjustment from Coosa County Commissioner			$0.00		
	Total patient payments to date Dec 11 2003				$0.00	
	Balance for Date of Service 12/11/2003					**$0.00**

TE OF SERVICE 1/7/2004

YSICIAN	JOHN JOHN JAMES MD	PROCEDURE	INSURANCE		PATIENT	
OCEDURE	PROCEDURE DESCRIPTION	CHARGES	PAYMENTS	ADJUSTMENTS	PAYMENT	BALANCE
80053	CHEM PANEL 14 COMPREHENSIVE METABOLIC	$15.00				
	Jan 23 2004 payment from Coosa County Commissioner		$15.00			
	Jan 23 2004 adjustment from Coosa County Commissioner			$0.00		
85025	CBC W PLATLETS	$15.00				
	Jan 23 2004 payment from Coosa County Commissioner		$15.00			
	Jan 23 2004 adjustment from Coosa County Commissioner			$0.00		
85651	ESR	$7.00				
	Jan 23 2004 payment from Coosa County Commissioner		$7.00			
	Jan 23 2004 adjustment from Coosa County Commissioner			$0.00		
99212	OFFICE OUTPATIENT VISIT EST L2	$40.00				
	Jan 23 2004 payment from Coosa County Commissioner		$40.00			
	Jan 23 2004 adjustment from Coosa County Commissioner			$0.00		
	Total patient payments to date Jan 7 2004				$0.00	
	Balance for Date of Service 1/7/2004					**$0.00**

TE OF SERVICE 12/10/2004

YSICIAN	MARTIN MARTIN ROACH D.O.	PROCEDURE	INSURANCE		PATIENT	
OCEDURE	PROCEDURE DESCRIPTION	CHARGES	PAYMENTS	ADJUSTMENTS	PAYMENT	BALANCE
81003	URINALYSIS	$7.00				
	Jan 13 2005 payment from Coosa County Commissioner		$7.00			
	Jan 13 2005 adjustment from Coosa County Commissioner			$0.00		
82570	URINE CREATININE DIPSTICK	$10.00				
	Jan 13 2005 payment from Coosa County Commissioner		$10.00			
	Jan 13 2005 adjustment from Coosa County Commissioner			$0.00		
99213	OFFICE OUTPATIENT VISIT EST L3	$50.00				
	Jan 13 2005 payment from Coosa County Commissioner		$50.00			
	Jan 13 2005 adjustment from Coosa County Commissioner			$0.00		
	Total patient payments to date Dec 10 2004				$0.00	
	Balance for Date of Service 12/10/2004					**$0.00**

TOTAL INSURANCE PAYMENTS	$196.00
TOTAL INSURANCE ADJUSTMENTS	$0.00
TOTAL PATIENT PAYMENTS	$0.00
OTHER CREDITS	$0.00
PAY THIS AMOUNT	**$0.00**

0 To 30 Days	30 To 60 Days	60 To 90 Days	90 or Greater
$0.00	$0.00	$0.00	$0.00

Your account is 120 days over due, if we do not receive payment we will turn this account over to a collection agency.

P.O.BOX 789
ALEXANDER CITY AL 35011-0789
Phone: (256)234-4131 Fax: (256)234-9979

Patient Demographics

Last:	First:	Middle:	Lineal:	Street:			
Kelley	Bryan		CCINMATE	Po Box 10 Attn: Donna			
SSN:	DOB:	Sex:		City:	State:	Zip:	Phone:
900-05-6528	06/17/1971	Male		ROCKFORD	AL	35136	(256)377-2211

Patient Insurance Information

Primary Insurer

Card Holder: Commision, Coosa County WC
Insurer: Coosa County Commissioner
Policy No.: 420256528
Group No.:
Relationship To Insured: Child
C0-Pay: $0.00

Secondary Insurer

Card Holder:
Insurer:
Policy No.:
Group No.:
Relationship To Insured:
C0-Pay:

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

PROVIDER INFORMATION

Physician: ROACH,MARTIN,G:D.O.
Service Date: 12/10/2004

DEMOGRAPHICS

KELLEY,BRYAN,CCINMATE
Po Box 10 Attn: Donna
ROCKFORD, AL 35136
Home Phone: (256)377-2211
DOB: 6/17/1971, Sex: Male, Race: Caucasian, SSN: 900056528
Employer: Coosa Co inmate, Phone: ( ) -

CLINICAL RECORDS

SUPER BILL

Diagnosis:

Code	Description
789.04	ABDOMINAL PAIN LEFT LOWER QUADRANT
810.8	LUMBAR LUMBOSAC FUS

Procedures:

Code	Description
81003	URINALYSIS
99213	OFFICE OUTPATIENT VISIT EST L3
82570	CREATININE URINE DIPSTICK

CHIEF COMPLAINT

checkup and check kidneys.
Medical Assistant: MARTIN,KATRINA:RN

VITAL SIGNS

Line	Temperature	Weight	Pulse	Systolic BP	Diastolic BP	Respiration	Height	Head Circ
1.	98.6	206	88	130	80	20	N/A	N/A

HISTORY OF PRESENT ILLNESS

OTHER routine check up.
GROIN urinary burning painful.

PERTINENT PAST HISTORY

HISTORY ---
-SURGICAL HISTORY: Extremities Lower Extremity & Back Surgery} Back, left - knee right -.
-PERSONAL MEDICAL HISTORY:
[Psychiatric Dz] Anxiety.
[Neurological Dz] Epilepsy/Seizure Disorder.

FAMILY AND PERSONAL HISTORY

HISTORY ---
-FAMILY MEDICAL HISTORY: Cancer Lung, Father Endocrine Dz diabetes Mother.
-SOCIAL HISTORY: No Drug, alcohol,tobacco abuse.

REVIEW OF SYSTEMS

Review of Systems
Gastrointestinal Abdominal Pain dull, aching llq for 4-5 days No nausea, vomiting, diarrhea, constipation denies blood in stool.
Constitutional no chronic fatique, fever, significant weight loss and night sweats..
MUSCULOSKELETAL back pain pt states "artificial l4 and l5 from trauma on lorcet for pain requesting more pain meds.

LAB

Urinalysis

AID	Value	Units	Assay
Color	yellow		Color
Clarity	clear	Clarity	
Uglu	neg	mg/dl	Glucose
Uket	neg		Ketone
SG	<1.005		Specific Gra
Ubld	large		Blood
pH	7.0	pH	
Unit	neg		Nitrite
Uleu	trace		Leukocytes
Upro	neg	mg/dl	Protein Urin
UCre	50	mg/dl	Urine Creati
PC	normal		Pro Creat Ra

Ordered:	12/10/2004 1:10:58 PM	By:	ROACH,MARTIN,G:D.O.
Collected:	12/10/2004 1:14:05 PM	By:	BARBER,SHEILA:J. MT(ASCP)
Resulted:	12/10/2004 1:14:44 PM	By:	BARBER,SHEILA:J. MT(ASCP)
Reviewed:	12/10/2004 1:34:00 PM	By:	ROACH,MARTIN,G:D.O.

PHYSICAL

PHYSICAL EXAMINATION --- Genitourinary Male normal exam sans hernia, prostate or genital abnormality Testicles Normal Exam Penis circumcised discharge none Gastrointestinal Abdominal tenderness: Left Lower Quadrant, No Renal Bruits No rebound tenderness No masses + BS: normoactive, Musculoskeletal Back surgical scar LS paraspinous tenderness range of motion good Neurological Reflexes: DTR 2+ bilaterally DTR equal and active at ankle and knees no foot drop ehl fxn intact.

ASSESSMENT AND PLAN

Assessment / Plan Prescriptions take medications as directed RTC in 2 weeks return SOONER if not getting better.

MEDICATION ALLERGIES

MEDICATION	SENSITIVITY	NOTATION
Codeine	UNKNOWN	

MEDICATIONS PRESCRIBED FOR THIS ENCOUNTER

MEDICATION	DOSE	UNIT	QTY	TYPE	REFLS	DOSES	UNIT	FREQUENCY	INSTRUCTIONS
Lorcet 10	0		10	tab	0	1	tab	QHS	prn pain
Naprosyn	500	mg	30	tab	1	1	tab	BID	take with food

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Medical Record For: KELLEY,BRYAN,WCP DOB --> Jun 17 1971 Age --> 32 Year(s) 7 Month(s)

Encounter Date: January 16, 2004
Physician: GOLDHAGEN,MICHELE,M:MD (PriCare, P.A.)

Phone Message

Time: 9:17 AM
From: GOLDHAGEN,MICHELE,M:MD
To: MARTIN,KATRINA:

Subject: Dr. Goldhagen can you do thisCrews drug store

Called and wanted to know if pt should still take his Zyprexia. LOV was 1-7-04 i reviewed office notes and it does not state to stop med..continue and f/u 2 weeks from last visit..MMG
No meds called in officer stated he had enough.dplpn

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Medical Record For: KELLEY,BRYAN,WCP DOB --> Jun 17 1971 Age --> 32 Year(s) 7 Month(s)

Encounter Date: January 12, 2004
Physician: JAMES,JOHN,M:MD (PriCare, P.A.)

Phone Message

Time: 10:24 AM
From: JAMES,JOHN,M:MD
To: MARTIN,KATRINA:

Subject: Crews

Pt is needing his Methocarbamol 750 mg BID. Lov was 1-04 with 0.00 bal----------OK 1 refill if time OK./jj
done dplpn

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Medical Record For: KELLEY,BRYAN DOB --> Jun 17 1971 Age --> 32 Year(s) 7 Month(s)

Encounter Date: January 7, 2004
Physician: JAMES,JOHN,M:MD (PriCare, P.A.)

Phone Message

Time: 2:34 PM
From: JAMES,JOHN,M:MD
To: MARTIN,KATRINA:

Subject: Liver tests abnormal---f/u in 2 weeks./jj

done dplpn

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Provider Information

Physician: JAMES,JOHN,M:MD
Service Date: 1/7/2004

Demographics

KELLEY,BRYAN,WCP
Po Box 10 Attn: Donna
ROCKFORD, AL 35136
Home Phone: (256)377-2211
DOB: 6/17/1971, Sex: Male, Race: Caucasian, SSN: 900056528
Employer: Coosa Co inmate, Phone: ( ) -

Super Bill

Diagnosis:

Code	Description
708.9	URTICARIA UNSPECIFIED

Procedures:

Code	Description
85025	CBC W PLATLETS
85651	ESR
80053	CHEM PANEL 14 COMPREHENSIVE METABOLIC
99212	OFFICE OUTPATIENT VISIT EST L2

Chief Complaint

body rash.
Medical Assistant: PARISH,DARLENE:G LPN

Vital Signs

Line	Temperature	Weight	Pulse	Systolic BP	Diastolic BP	Respiration	Height	Head Circ
1.	98	204	87	130	70	20	N/A	N/A

Pertinent Past History

HISTORY ---
-SURGICAL HISTORY: Extremities Lower Extremity & Back Surgery} Back, left - knee right -.
-PERSONAL MEDICAL HISTORY:
[Psychiatric Dz] Anxiety.
[Neurological Dz] Epilepsy/Seizure Disorder.

Family and Personal History

HISTORY ---
-FAMILY MEDICAL HISTORY: Cancer Lung, Father Endocrine Dz diabetes Mother.
-SOCIAL HISTORY: No Drug, alcohol,tobacco abuse.

History of Present Illness

OTHER body rash.

Review of Systems

Lab

CBC with Platelet

AID	Value	Units	Assay
WBC	5.8	K/uL	White Blood
Lym	1.9	K/uL	Lymphocytes
Lymper	33.0	%	Lymphocyte p
Mid	0.6	K/uL	Monos, Eos,
Midper	11.1	%	Mono, Eo, Ba
Gran	3.2	K/uL	Granulocytes
Granper	55.9	%	Granulocyte
RBC	4.51	M/uL	Red Blood Ce
Hgb	15.7	g/dl	Hemoglobin
Hct	42.6	%	Hematocrit
MCV	94.4	fl	MCV
MCH	34.8	pg	MCH
MCHC	36.9	g/dl	MCHC
RDW	14.1	%	RDW
PLT	286	K/uL	Platelets

Ordered: 1/7/2004 9:30:20 AM By: JAMES,JOHN,M:MD
Collected: 1/7/2004 9:31:00 AM By: BARBER,SHEILA:J. MT(ASCP) LAB

Resulted:	1/7/2004 9:34:54 AM	By:	BARBER,SHEILA:J. MT(ASCP) LAB
Reviewed:	1/7/2004 2:33:58 PM	By:	JAMES,JOHN,M:MD

ESR

AID	Value	Units	Assay
ESR	12	mm/hr	Sed Rate

Ordered:	1/7/2004 9:30:26 AM	By:	JAMES,JOHN,M:MD
Collected:	1/7/2004 9:31:01 AM	By:	BARBER,SHEILA:J. MT(ASCP) LAB
Resulted:	1/7/2004 10:36:11 AM	By:	BARBER,SHEILA:J. MT(ASCP) LAB
Reviewed:	1/7/2004 2:34:00 PM	By:	JAMES,JOHN,M:MD

Comprehensive Metabolic Panel

AID	Value	Units	Assay
Na	144	mmol/L	Sodium
K	4.2	mmol/L	Potassium
Cl	102	mmol/L	Chloride
CO2	29	mEq/L	CO2
Cr	0.8	mg/dl	Creatinine
BUN	9	mg/dl	BUN
Gluc	97	mg/dl	Serum Glucos
Ca	9.7	mg/dl	Calcium
ALT_SGPT	763	U/L	ALT(SGPT)
AST_SGOT	284	U/L	AST(SGOT)
AlkPhos	219	U/L	Alkaline Pho
TBili	1.5	mg/dl	Total Biliru
Alb	4.4	g/dL	Albumin
TP	7.1	g/dL	Total Protei

Ordered:	1/7/2004 9:30:30 AM	By:	JAMES,JOHN,M:MD
Collected:	1/7/2004 9:31:02 AM	By:	BARBER,SHEILA:J. MT(ASCP) LAB
Resulted:	1/7/2004 2:27:12 PM	By:	BARBER,SHEILA:J. MT(ASCP) LAB
Reviewed:	1/7/2004 2:34:09 PM	By:	JAMES,JOHN,M:MD

Physical

PHYSICAL EXAMINATION --- Constitutional Hydration OK. Respiratory clear to P+A Heart RR no murmur Diffuse urticarial rash..

Assessment and Plan

Assessment / Plan Will call with test results when they are available. Discharge Instructions Take medications as prescribed. Drink plenty of fluids, Get adequate rest..

Prescriptions

Dispense: Atarax 25 mg, sig: 1 tab, Q 4 Hrs prn itching, 40 tab, 1 Refill(s).

Drug Allergies

Codeine

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Medical Record For: KELLEY,BRYAN DOB --> Jun 17 1971 Age --> 32 Year(s) 7 Month(s)

Encounter Date: January 6, 2004
Physician: JAMES,JOHN,M:MD (PriCare, P.A.)

Phone Message

Time: 2:58 PM
From: JAMES,JOHN,M:MD
To: HARRIS,CINDY:D

Subject: srgt called here about his med

Pt broke out.. said they called pharmacy and the pharmacist told them that he had a side effect to Robaxin.. they seemed to say that we doubled it. But I thought it was just his Zyprexia.. so not sure.. Please advise. Do we need pt to come in..? #256-377-1803 to call Coosa Cnty comm----------
OV 1/07./jj

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Medical Record For: KELLEY,BRYAN DOB --> Jun 17 1971 Age --> 32 Year(s) 7 Month(s)

Encounter Date: January 2, 2004
Physician: JAMES,JOHN,M:MD (PriCare, P.A.)

Phone Message

Time: 11:40 AM
From: JAMES,JOHN,M:MD
To: MARTIN,KATRINA:

Subject: Crews

LOV 12/11/03 -- (in jail) -- given Methocarbamol 750mg BID prn #28 request refill -- also needs Zyprexa changed we gave 5mg because mother said this was the dosage-- jail called said pt is acting awful can't do anything with him and they said mother told them she was inncorrect on the Zyprexa it is suppose to be 20mg.-- I called FW to confirm it is 20mg -- they want to know can we change--------OK 1 month on each./jj Done km

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Medical Record For: KELLEY,BRYAN DOB --> Jun 17 1971 Age --> 32 Year(s) 6 Month(s)
Encounter Date: December 12, 2003
Physician: JAMES,JOHN,M:MD (PriCare, P.A.)

Phone Message

Time: 4:29 PM
From: JAMES,JOHN,M:MD
To: BARBER,SHEILA:J. MT(ASCP) LAB

Subject: Crews Drug

Pt is needing his Robaxin 750mg. Was just here.----------OK 1 refill./jj
Rx called to pharmacy 12/12/03 @ 1635/SJB

PriCare, P.A.
44 Aliant Parkway
ALEXANDER CITY, AL 35010-0789
Phone: (256)234-4131 Fax: (256)234-9979

Provider Information
Physician: JAMES,JOHN,M:MD
Service Date: 12/11/2003

Demographics
KELLEY,BRYAN
Po Box 10 Attn: Donna
ROCKFORD, AL 35136
Home Phone: (256)377-2211
DOB: 06/17/1971, Sex: Male, Race: Unknown, SSN: 900056528

Super Bill
Diagnosis:

Code	Description
719.49	ARTHRALGIA MULTI SITES

Procedures:

Code	Description
J0702	INJ CELESTONE
99212	OFFICE OUTPATIENT VISIT EST L2

Chief Complaint
Need my shoulder knee and lower back hurts.
Medical Assistant: MARTIN,KATRINA:

Vital Signs

Line	Temperature	Weight	Pulse	Systolic BP	Diastolic BP	Respiration	Height	Head Circ
1.	98.6	191	78	110	70	20	N/A	N/A

Pertinent Past History
HISTORY ---
-SURGICAL HISTORY: Extremities Lower Extremity & Back Surgery} Back, left - knee right -.
-PERSONAL MEDICAL HISTORY:
[Psychiatric Dz] Anxiety.
[Neurological Dz] Epilepsy/Seizure Disorder.

Family and Personal History
HISTORY ---
-FAMILY MEDICAL HISTORY: Cancer Lung, Father Endocrine Dz diabetes Mother.
-SOCIAL HISTORY: No Drug, alcohol,tobacco abuse.

History of Present Illness
LEFT SHOULDER pain.
RIGHT KNEE pain.
BACK pain lower.

Physical
PHYSICAL EXAMINATION --- Constitutional Hydration OK. Wearing handcuffs. Ear, Nose, Mouth and Throat Normocephalic Neck supple and nontender. Respiratory clear to P+A Heart RR no murmur Gastrointestinal GI soft BSx 4 without tenderness, distention, HSM or masses Shoulders tender anteriorly..

Assessment and Plan
Celestone 6mg. IM..
Continue present meds..

Injections
Administered INJ CELESTONE 1 cc Intramuscular Left Glutteusmaximus

Ordered:	12/11/2003 12:01:42 PM	By:	JAMES,JOHN,M:MD
Collected:	12/11/2003 12:22:37 PM	By:	PARISH,DARLENE:G LPN
Injected:	12/11/2003 12:22:39 PM	By:	PARISH,DARLENE:G LPN

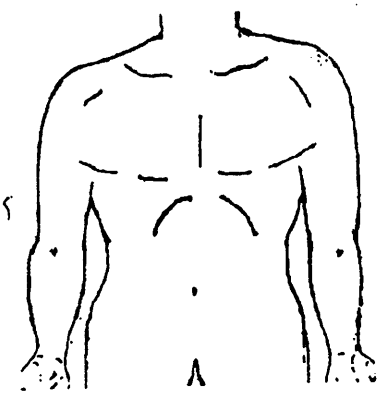
Prescriptions
Dispense: Zyprexa 5 , sig: 1 tab, HS , 20 tab, 0 Refill(s).
Dispense: Neurontin 300 , sig: 1 cap, TID , 90 cap, 2 Refill(s).
Dispense: Klonopin 2 mg, sig: 1 tab, BID , 60 tab, 2 Refill(s).
Dispense: Phenobarbital 60 mg, sig: 1 tab, BID , 60 tabs, 5 Refill(s).
Dispense: Seroquel 200 mg, sig: 1 tab, TID , 90 tab, 0 Refill(s).
Dispense: Robaxin 750 mg, sig: 2 tab, BID , 28 tab, 0 Refill(s).

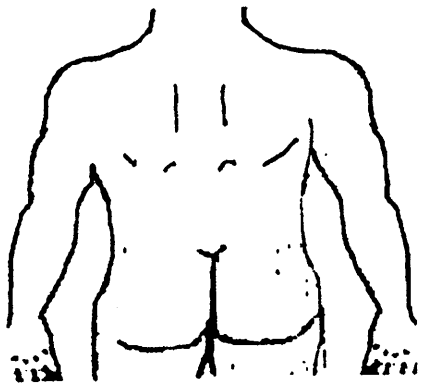
Drug Allergies
Codeine

RUSSELL MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD
PAGE 2

GENERAL
ADULT ILLNESS

PLAINTIFF'S EXHIBIT 6 LAD





RECTAL
☐ heme neg ☐ heme positive

BACK
☐ normal ☐ CVA tenderness

SKIN
☐ normal ☐ rash

EXTREMITIES
☐ normal ☐ tenderness
☐ no pedal edema ☐ Homan's sign
☐ pedal edema

NEUROLOGICAL
☐ gait normal ☐ ataxia
☐ CN II-XII intact ☐ focal weakness/sensory loss
☐ no focal weakness
☐ no sensory loss

PSYCHIATRIC
☐ oriented x 3 ☐ disoriented: person / place / time
☐ mood/affect nl ☐ depressed

Cardiac monitor strip: ☐ NSR ☐ no ectopy

EKG Rhythm — Rate: _____
☐ NSR ☐ tachycardia ☐ bradycardia ☐ paced
☐ atrial fib / flutter ☐ ectopy: atrial / ventricular
☐ heart block: 1st / 2nd / 3rd degree

Axis: ☐ normal ☐ Axis deviation: Left / Right
QRS: ☐ normal ☐ IVCD ☐ RBBB ☐ LBBB
ST/T : ☐ normal ☐ nonspecific changes
☐ ST segments elevated / depressed _____
☐ T waves flat / inverted _____

Impression: ☐ normal EKG ☐ abnormal EKG: _____
☐ Comparison to previous EKG ☐ unchanged _____

CXR: ☐ normal ☐ abnormal _____

Other radiological studies: _____

CBC: ☐ normal BMP: ☐ normal

segs: ___%
bands: ___%
lymphs: ___%

Cardiac Profile: ☐ normal except: _____
LFTs: ☐ normal except: _____
U/A : ☐ normal except: _____
PT / PTT: ☐ normal _____
Amylase: ☐ normal _____

ED COURSE

Treatment Response

☐ old records reviewed ☐ Admission orders written
☐ discussed with Dr. _____
☐ Counseled patient/family: test results / diagnosis / follow-up

CLINICAL IMPRESSION

DISPOSITION (time: _____)
☐ home ☐ admit ☐ transferred ☐ AMA ☐ observation ☐ expired
Condition: ☐ stable ☐ fair ☐ good ☐ poor ☐ critical ☐ improved
Follow-up: ☐ ED ☐ PMD ☐ on-call _____ in ____ days
Instructions: _____
Rx: _____

ATTENDING NOTE
☐ Resident/NP/PA note reviewed ☐ pt interviewed ☐ pt examined
Pertinent HPI: _____
My exam reveals: _____
☐ Labs reviewed ☐ X-rays reviewed
☐ I agree with above diagnosis ☐ I have reviewed the treatment plan / concur

_____ Resident / NP / P
_____ MD / DO

☐ See Addendum Sheet

RUSSELL ME; AL CENTER
EMERGENCY PHYSICIAN RECORD 20 GENERAL
ADULT ILLNESS

Time Seen: _____ Room: _____
Historian: patient / EMS / sheriff
History limited by: AMS / Translator

ER
KELLEY, DANIEL E.
DR. WILLIAMS, K
01/16/2004 MEDICARE

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS:

age: _____ race: W / B / H / O gender: M / F

sig mvc fem 7th
crush and 3d Hx
EMS chronic urine. Sheriff
called drowsy, sleep
Pt used's last week/also
Hx Acute psychotic
drug induced/acute but
has not used x 2½ w
discontinued

Onset: _____ hrs / days / weeks see above

Timing: persists worse better resolved constant intermittent

Severity of symptoms: mild moderate severe
pain scale (1—10): _____

Exacerbating factors: ☐ none

Alleviating factors: ☐ none

Similar symptoms previously: YES NO

PAST MEDICAL HISTORY

- ☐ HTN
- ☐ Cardiac disease
- ☐ COPD / Asthma
- ☐ Pneumonia
- ☐ Renal disease
- ☐ Cancer
- ☐ Other: bipolar vs schizoaff hx HTN, substance/alcohol abuse chronic LBP
- ☐ none
- ☐ CVA
- ☐ TIA
- ☐ Seizures
- ☐ Diabetes
- ☐ peptic ulcer disease

SURGERIES

chronic LBP

FAMILY HISTORY

SOCIAL HISTORY

- ☐ Alcohol
- ☐ Tobacco ?
- ☐ Drug Abuse
- ☐ Lives alone / spouse / family / nursing home

MEDICATIONS ☐ see nurse's notes

ALLERGIES ☐ NKDA

☐ see nurse's notes
11 dell cert
Penicillin

REVIEW OF SYSTEMS

☐ ROS NEGATIVE EXCEPT AS INDICATED
☐ ROS cannot be obtained; patient unable to answer questions
Check box if system is normal

☐ General	☐ fever	☐ weight loss
	☐ chills	
☐ ENT:	☐ sore throat	☐ nasal congestion
☐ Resp:	☐ cough	☐ SOB / DOE
	☐ wheeze	
☐ CV:	☐ chest pain	
☐ GI:	☐ nausea	☐ diarrhea
	☐ vomiting	☐ constipation
	☐ abdominal pain	
☐ GU:	☐ flank pain	☐ urgency
	☐ dysuria	☐ frequency
	☐ hematuria	
	LNMP: _____	
☐ Skeletal:	☐ myalgia	☐ arthralgia
	☐ back pain	chronic.
☐ Skin:	☐ rash	icterus.
☐ Neuro/Psych	☐ headache	☐ anxiety
	☐ confusion	☐ focal weakness
☐ Endocrine:	☐ weight change	
	☐ polyuria / polydypsia	

ADDITIONAL HISTORY

[redacted]

PHYSICAL EXAM

☐ vital signs reviewed icteric

HR 110 Bp _____ RR _____ T _____ SaO_2 % _____

APPEARANCE:
☐ normal icteric ☐ distressed: mild / moderate / severe

HEENT
☐ Normal
☐ icteric
☐ pharyngeal erythema
☐ nasal congestion / drainage
☐ TM erythema

NECK
☐ Normal
☐ cervical adenopathy
☐ thyromegaly

RESPIRATORY
☐ NL breath sounds
☐ wheezing / rales / rhonchi
☐ respiratory distress

CARDIAC
☐ RRR
☐ No murmur
☐ abnormal rate: slow / fast
☐ abnormal rhythm
☐ murmur __/6 systolic / diastolic

ABDOMEN
☐ Non-tender
☐ NL bowel sounds
☐ no organomegaly
☐ tenderness (see diagram)
☐ guarding / rebound
☐ bowel sounds: increased/decreased

RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED. REC. #: M0124352
PATIENT STATUS: DIS IN

DISCHARGE SUMMARY

DATE OF ADMISSION: 1-16-04

DATE OF DISCHARGE: 1-20-04

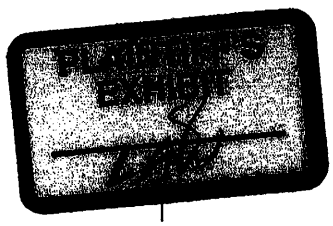
DISCHARGE DIAGNOSES:
1. With possible hepatic encephalopathy .
2. Probably drug induced hepatitis.

SECONDARY DIAGNOSES:
1. History of alcohol abuse.
2. Chronic lower back pain.
3. History of migraine headache.
4. History of bipolar disorder.

PROCEDURES: Abdominal US which revealed moderate hepatomegaly with diffuse gallbladder wall thicken.

CONSULTANTS:
1. Dr. Holcombe, GI.

REASON FOR ADMISSION AND HOSPITAL COURSE: Mr. Kelley is a 32 year old white male with the above mentioned medical problems, who apparently was discharged from jail earlier on the day of admission and presented to the emergency room complaining of fatigue, malaise, increased lethargy and noted jaundice. He also reported some increased abdominal girth. He had reported gradual ongoing symptoms over the past 4 to 5 weeks. He had not had any vomiting, diarrhea or constipation. He apparently has been incarcerated for approximately 2 1/2 months and there has been some type of confusion in terms of administration of his medications. He apparently has been receiving high doses of Zyprexa, Neurontin, Clonopin, Phenobarbitol, Seroquel and Robaxin. He has seen Dr. James in the past which I was covering on the day of admission. Patient denied any recent alcohol use and he has been incarcerated in jail for the past 2 1/2 months. On admission he was afebrile and his vital signs were stable. He did appear extremely jaundice. His sclera was icteric. Lungs were clear. Cardiovascular exam revealed no murmurs, gallops or rubs. The abdominal exam was protuberant with positive fluid wave test. No masses could be appreciated. No calf tenderness. He did have noted asterixis of the hands, some mild clonus of the ankles bilaterally. Upon admission his PT INR is 1.5. His total bilirubin was 7.9 with AST of 1443, ALT of 3425, elevated alkaline phos of 241. His ammonia level was slightly elevated at 37. H & H was stable. Had no elevated white count or left shift. Platelet count also was normal. He was subsequently admitted to ICU for possible hepatic encephalopathy VS sedation secondary to his meds. He was started on neurochecks. Acetaminophen levels were obtained which were unremarkable. GI consultation was obtained with Dr. Holcombe. Hepatitis profile also was obtained but was pending on the day of discharge. His mental status improved markedly with supportive treatment. He was empirically started on PO Lactulose upon admission. After long extensive discussion with he and his family I discussed the case with Dr. Dickerson, gastroenterologist in Birmingham, whom the family had requested to see. After discussion it si felt that the patient was stable enough for discharge with follow up on outpatient basis. The patient was subsequently discharged in stable condition. He did complain of some



RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED. REC. #: M0124352
PATIENT STATUS: DIS IN

DISCHARGE SUMMARY

dysuria. On the day prior to discharge and did have some significant pyuria and was started on Bactrim .

DISCHARGE DIET: Low sodium.

DISCHARGE MEDICATIONS:
1. Lactulose 30 cc po tid.
2. Bactrim DS one po bid for additional 9 days.

DISCHARGE INSTRUCTIONS:
The patient is to follow up with Dr. Dickerson at Brookwood Medical Center later on the day of discharge either later in the am or in the afternoon. I did discuss with him precautions to take in terms of potential hepatotoxic medications including Alcohol, Tylenol and Herbal products.

Vincent Law, M.D.

VL/jmc
D: 02/01/04 1136
T: 02/01/04 1236

Russell Hospital

KELLEY,DANIEL B. D/C 01/20/2004 4 Law,Vincent M0124352
Gender : Male
Age : 32
Disposition : Home, Self Care (1)

Medicare DRG

205 DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS, ALCOHOLIC HEPATITIS with CC

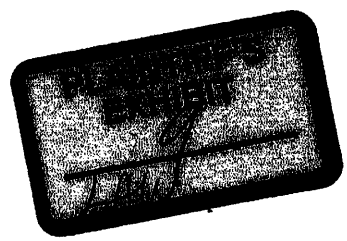
CMS wt 1.2095 A/LOS 6.2 G/LOS 4.6

Principal Diagnosis

*5722 HEPATIC COMA

Secondary Diagnoses

*5733 HEPATITIS
#5990 URINARY TRACT INFECTION, SITE NOT SPECIFIED
7242 LUMBAGO (LOW BACK PAIN)
34690 UNSPECIFIED MIGRAINE WITHOUT INTRACTABLE MIGRAINE
2967 BIPOLAR AFFECTIVE DISORDER, UNSPECIFIED
9779 POISONING BY UNSPECIFIED DRUG OR MEDICINAL SUBSTANCE



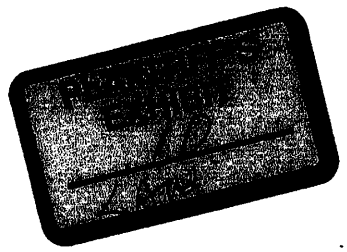
RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010585651
PHYSICIAN: Law,Vincent
MED. REC. #: M0124352
PATIENT STATUS: DIS IN

DISCHARGE SUMMARY

DATE OF ADMISSION: 1-28-04

DATE OF DISCHARGE: 2-1-04



DISCHARGE DIAGNOSES:
1. Dehydration, resolved.
2. Probable drug induced hepatitis, resolving.
3. Chronic lower back pain.
4. History of bipolar disorder.
5. History of migraine headaches.

SECONDARY DIAGNOSES:

PROCEDURES:
1. US of the gallbladder which was normal.
2. MRI of the head with and without contrast which again also was unremarkable except for questionable ethmoiditis.
3. CT of the head with and without contrast which again was normal.
4. CT of the abdomen and pelvis with and without contrast which revealed possible mild dilatation of the atrial hepatic biliary system, however there is no abnormality of the pancrease.

CONSULTANTS: None.

REASON FOR ADMISSION AND HOSPITAL COURSE: Mr. Daniel Kelley is a 32 year old white male, who was recently discharged here from Russell Medical Center and also discharged from Brookwood Hospital under Dr. Dickenson's care, who presented to the emergency room complaining of nausea, vomiting and diarrhea with vague abdominal pain. No history of fever or chills. No dysuria, no cough or congestion. He apparently has seen Dr. James in the past and I was covering for him on the day of his initial admission January 16 when he presented with decrease level of consciousness and elevated liver function test along with clinical jaundice. Apparently he had recently been incarcerated and there was some confusion in terms of the dosages of his medications and had been given Zyprexa, Neurontin, Clonopin, Phenobarbitol, Seroquel and Robaxin. At that time as mentioned above his liver function test were markedly elevated and he was hospitalized and after further discussion with Dr. Dickerson, gastroenterologist in Birmingham at the request of his family the patient was discharged and instructed to follow up with Dr. Dickerson the following day in his office. Upon presentation here to the emergency room he was noted to be hypotensive, however his LFT's and total bilirubin had improved. He had no elevated white count or left shift. PT and PTT were normal. Platelet count was normal. He was subsequently admitted and started on IV fluid hydration. His liver function test continued to gradually improve. He continued to have vague headaches and CT and MRI of his head was obtained as mentioned above. Patient's appetite improved and he was feeling somewhat better. After further discussion with Dr. Holcombe it was felt that the patient could be managed on an outpatient basis, however I did recommend that the patient be house confined for at least 2 months. Encourage po fluid intake and for rest and recovery. I also discussed with Dr. Kelley in

RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010585651
PHYSICIAN: Law,Vincent
MED. REC. #: M0124352
PATIENT STATUS: DIS IN

DISCHARGE SUMMARY

regards to precautions to help protect his liver and that would include no over the counter Actaminophen, herbal products and Alcohol use. The patient is scheduled to see Dr. Holcombe on 2-3-04 for follow up and he was subsequently discharged home in stable condition. I did encourage him to follow up with his psychiatrist in two to three weeks for management of his bipolar disorder.

DISCHARGE DIET: Regular.

DISCHARGE MEDICATIONS:
1. Over the counter Motrin, prn severe headaches.

DISCHARGE INSTRUCTIONS:
1. The patient is to follow up Dr. Holcombe on Feb 3 as scheduled.
2. Encourage PO fluids.
3. Follow up with his psychiatrist in two to three weeks.
4. He is to remain house confined for at least two months until his liver function test improve and/or normalized.

Vincent Law, M.D.

VL/jmc
D: 02/01/04 1109
T: 02/01/04 1200

PLAINTIFF'S EXHIBIT 44

EMERGENCY DEPARTMENT
NURSING ASSESSMENT SHEET

V 010585651 MO124352

ER ER
KELLEY, DANIEL B.
DR. GOLDHAGEN, M
01/28/2004 MEDICARE
32Y CA/M 06/17/1971
CODIENE

PERSONAL PHYSICIAN: Law | Holcombe ER PHYSICIAN: Goldhagen

NOTIFIED ( ) BEEPED ( ) TIME ____ INT ____ NOTIFIED ( ) TIME ____ INT ____

RESPONDED ( ) TIME ____ RESPONDED ( ) TIME ____

PHYSICIAN ON CALL FOR UNATTACHED PATIENTS ____ 989 00 RA

TEMP 99.5 PULSE 80 RESP 18 B/P 119/62 WT ____ CHIEF COMPLAINT: presents to ER c family. pt co vomiting x 4 times since noon today. pt family describes as "foul smelling yellow". family states "Dr. Holcombe told us, " that he possibly could of had small stroke on [illegible] pt co severe HA

NURSE Espeland TIME 1737

FAMILY NOTIFIED: YES ( ) NO ( ) TIME ____ PERSON ____

ALLERGIES: NKDA
codeine

POLICE NOTIFIED: YES ( ) NO ( ) TIME ____ PERSON ____

SOCIAL SERV. NOTIFIED: YES ( ) NO ( ) TIME ____ PERSON ____

CORONER NOTIFIED: YES ( ) NO ( ) TIME ____ PERSON ____

CURRENT MEDICATIONS: ____

PRIORITY:
EMERGENT ( )
URGENT ( )
NONURGENT ( )

MODE OF ARRIVAL:
AMBULATORY ( )
PERSONAL VEHICLE ( )
WHEELCHAIR ( )
IN ARMS ( )
AMBULANCE ( )

TETANUS HX:
UTD ( )
UNKNOWN ( )

PEDIATRIC IMMUNIZATIONS:
UTD ( )
UNKNOWN ( )

TX PRIOR TO ARRIVAL:
NONE ( )
O2 ( )
BCLS ( )
ACLS ( )
IV ( )
BACKBOARD ( )
C-COLLAR ( )
SPLINT ____
BANDAGE ____

PAST MEDICAL HISTORY:
RENAL DZ ( )
HEART DZ ( )
SEIZURE ( )
HTN ( )
DIABETES ( )
COPD / ASTHSIMA ( )
CANCER kidneys
OTHER Liver failure

TIME	IV FLUIDS	AMOUNT	SITE	GAUGE	NURSE
1835	NS	1 liter	ER	20g	Espeland

CODES FOR MEDICATION ADMINISTRATION SITES:
A) LEFT HIP C) LEFT THIGH E) LEFT ARM G) LEFT ABD
B) RIGHT HIP D) RIGHT THIGH F) RIGHT ARM H) RIGHT ABD

TIME	T	P	R	B/P	Sa O2	MEDICATION / TREATMENTS	DOSE	ROUTE	SITE	NURSE	COMMENTS / PT RESPONSE

MENTAL STATUS: (ALERT) ORIENTED DROWSY LETHARGIC DISORIENTED UNRESPONSIVE CONFUSED

STIMULUS RESPONSE: N/A (VERBAL) TOUCH PAIN NONE

HAND GRIPS: N/A (EQUAL) STRONG WEAK RIGHT LEFT

MOVEMENT: N/A (VOLUNTARY) INVOLUNTARY

PUPIL RESPONSE: N/A (PERRLA) SLUGGISH BRISK NONREACTIVE

MUCUS MEMBRANES: N/A (MOIST) DRY

SKIN TURGOR: N/A (NORMAL) DECREASED

SKIN: (WARM) HOT DRY COOL MOIST COLD CLAMY

COLOR: NORMAL FLUSHED PALE (JAUNDICE) CYANOTIC MOTTLED DUSKY

PULSE: (REGULAR) IRREGULAR WEAK ABSENT

RESPIRATION: (ADEQUATE) LABORED SHORT OF BREATH HYPERVENTILATING SHALLOW

BREATH SOUNDS: N/A (BBS = CLEAR) ADVENTITIOUS DIMINISHED ABSENT LEFT ( ) RIGHT ( )

SPEECH: (CLEAR) COHERENT INCOHERENT SLURRED ABUSIVE

11127084

RUSSELL MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD

1 ABDOMINAL / FLANK PAIN
GI SYMPTOMS

ER
KELLEY, DA L B.
DR. GOLDHAGEN, M
01/28/2004 MEDICARE
32Y CA/M 06/17/1971
CODIENE

Time Seen: 615P Room: F
Historian: patient / EMS / Parent
History limited by: ________ ☐ Translator

CHIEF COMPLAINT: ☐ nausea ☐ abdominal pain ☐ vomiting ☐ flank pain ☐ diarrhea

FAMILY HISTORY
☐ GB disease ☐ kidney stones

SOCIAL HISTORY
☐ Alcohol
☐ Tobacco
☐ Drug Abuse — ?
☐ Lives alone / spouse family / nursing home

HISTORY OF PRESENT ILLNESS:
age: 32 race: W / B / H / O gender: M / F

N/V feels weak / Tired
? pain in abd — distention
Recent Admit — ICU (30 days) — discharged d/c 22 days ago

Onset: 2 hrs / days / weeks
Timing: persists worse better resolved
Severity of symptoms: mild moderate severe
maximum pain scale: 1 2 3 4 5 6 7 8 9 10
Description of pain: ☐ cramping ☐ sharp / stabbing ☐ aching ☐ burning ☐ dull / pressure

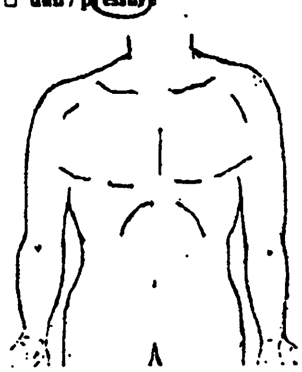
MEDICATIONS ☐ see nurse's notes
Ø

ALLERGIES ☐ NKDA
☐ See nurse's notes
Codeine

REVIEW OF SYSTEMS
☑ ROS NEGATIVE EXCEPT AS INDICATED
☐ ROS cannot be obtained; patient unable to answer questions
Check box if system is normal

☐ General	☐ fever	☐ chills	☐ weight loss	
☐ Eyes:	☐ visual complaints			
☐ ENT:	☐ sore throat	☐ nasal congestion		
☐ Resp:	☐ cough	☐ wheeze	☐ SOB / DOE	
☐ CV:	☐ chest pain			
☐ GI:	☐ melena	☐ hematochezia	☐ heart burn	
	☐ constipation	☐ esophageal reflux symptoms		
☐ GU:	☐ flank pain	☐ urgency	☐ dysuria	
	☐ frequency	☐ hematuria		
	LNMP: ____			
☐ Skeletal:	☐ calf pain / leg pain			
	☐ back pain	☐ arthralgia		
☐ Skin:	☐ rash			
☐ Neuro/Psych:	☐ headache (dizziness)	☐ anxiety	☐ confusion	
	☐ focal weakness			
☐ Endocrine:	☐ weight change	☐ polyuria / polydypsia		

Location of pain: diffuse
RUQ epigastric
RLQ periumbilical
LUQ perineal
LLQ flank



Associated symptoms:
☐ nausea ☐ loss of appetite / anorexia
☐ vomiting x ____ bilious / bloody ☐ chest discomfort
☐ diarrhea x ☐ SOB / DOE
☐ dysuria/frequency/urgency ☐ vaginal discharge

Exacerbating factors:
☐ none
☐ sick contacts ☐ association to food / bad meal
☐ recent antibiotic ☐ medication : ASA / NSAID
☐ recent foreign travel ☐ chronic vomiting/diarrhea
Similar symptoms previously: YES / NO

ADDITIONAL HISTORY

PLAINTIFF'S EXHIBIT

PAST MEDICAL HISTORY
☐ PUD ☐ Gall Bladder Disease ☐ None
☐ Pancreatitis ☐ Hepatitis / Cirrhosis ☐ HTN
☐ Pyelonephritis ☐ Recurrent UTIs ☐ Ovarian cyst
☐ Kidney stones ☐ Urethritis ☐ Diabetes
☐ CAD ☐ Diverticulitis
☐ Cancer ICFT
☐ Other :

SURGERIES
☐ cholecystectomy ☐ appendectomy ☐ renal surgery
☐ bowel surgery ☐ gastric surgery ☐ hysterectomy
☐ C-section ☐ aortic aneurysm ☐ CABG
Ø

PHYSICAL EXAM ☐ vital signs reviewed
HR ____ Bp ____ RR ____ T ____ SaO_2 % ____
APPEARANCE: Tired
☐ normal ☐ distressed: mild / moderate / severe
HEENT
☐ normal MM dry ☐ icteric ☐ pharyngeal erythema
☐ nasal congestion / drainage
☐ TM erythema
NECK
☐ normal ☐ cervical adenopathy

RUSSELL MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD
PAGE 2

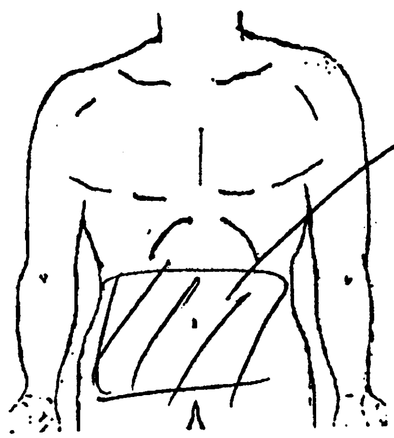
ABDOMINAL / FLANK PAIN
GI SYMPTOMS

CARDIO-PULMONARY
- ☐ NL breath sounds
- ☐ RRR
- ☐ No murmur
- ☐ wheezing / rales / rhochi R / L
- ☐ respiratory distress
- ☐ abnormal rate: slow / fast
- ☐ abnormal rhythm
- ☐ murmur __/6 systolic / diastolic

ABDOMEN
- ☐ soft
- ☐ non-tender
- ☐ nondistended
- ☐ NL bowel sounds
- ☐ no organomegaly
- ☐ no mass
- ☐ rigid
- ☐ tenderness (see diagram)
- ☐ distended
- ☐ guarding / rebound
- ☐ bowel sounds: *increased/decreased*
- ☐ mass/ organomegaly: ______

RECTAL
- ☐ heme neg
- ☐ heme positive *maroon / black / bloody*

BACK
- ☐ normal
- ☐ CVA tenderness



Mild *Moderate* *Severe*

MALE GU
- ☐ normal
- ☐ testicles non-tender

FEMALE GU
- ☐ external genitals NL
- ☐ vaginal / cervix NL
- ☐ bimanual exam NL
- ☐ vaginal discharge / bleeding
- ☐ Os open ☐ CMT
- ☐ Uterine tenderness
- ☐ Adnexal tenderness/mass R / L

SKIN
- ☐ normal
- ☐ rash ______

EXTREMITIES
- ☐ normal
- ☐ no pedal edema
- ☐ tenderness ______
- ☐ pedal edema

NEUROLOGICAL
- ☐ gait normal
- ☐ CN II-XII intact
- ☐ no focal weakness
- ☐ ataxia
- ☐ focal weakness/sensory loss

Cardiac monitor strip: ☐ NSR ☐ no ectopy

EKG Rate: ______
Rhythm: ☐ NSR ☐ tachycardia ☐ bradycardia ☐ paced
☐ atrial fib / flutter ☐ ectopy: atrial / ventricular
☐ heart block: 1st / 2nd / 3rd degree
Axis: ☐ normal ☐ Axis deviation: Left / Right
QRS: ☐ normal ☐ IVCD ☐ RBBB ☐ LBBBB
ST/T: ☐ normal ☐ nonspecific changes
☐ ST segments elevated / depressed ______
☐ T waves flat / inverted ______
Impression: ☐ normal EKG ☐ abnormal EKG: ______
Comparison to Old EKG ☐ unchanged ______

CXR: ☐ normal ☐ abnormal ______
KUB: ☐ normal ☐ abnormal
Upright: ☐ normal ☐ *Air/fluid levels* ☐ *free air* ☐ *excess stool*
IVP: ☐ normal ______
CT Scan: Abdomen / Pelvis ☐ normal ☐ abnormal ______
Ultrasound: *Gallbladder* *Pancreas* *Aorta* *Kidneys* *Pelvis / Vaginal* *Testicle* ☐ normal ☐ abnormal

CBC: ☐ normal BMP: ☐ normal
segs ___% bands ___% lymphs ___%
See chart

Cardiac Profile: ☐ normal except: ______
PT / PTT: ☐ normal ______
LFTs/Amylase: ☐ normal ______
HCG: ☐ negative ☐ positive
ABG: pH: ______ $PaCO_2$: ______ PaO_2: ______
U/A: ☐ normal except ______

ED COURSE

840 — Labs back — D/W Holcombe
Refuses to admit
930 — Cobb — Admit (Hayduke / Ortho)

CRITICAL CARE TIME: ______ (minutes)

☐ old records reviewed ☐ Admission orders written
☐ discussed with Dr. ______
☐ counseled patient/family: test results / diagnosis / follow-up

CLINICAL IMPRESSION
Acute abdominal pain *Reflux esophagitis* *Diverticulitis* *Vomiting / Diarrhea* *Bowel Obstruction*
Pancreatitis *Cholecystitis* *Gastroenteritis* *Aortic aneurysm* *Bowel perforation*
Peptic Ulcer Disease *Appendicitis* *Kidney Stones / renal colic* *Pyelonephritis* *Pelvic inflammatory disease*

Dehydration — Transaminitis

DISPOSITION (time: ______)
☐ home ☐ admit ☐ transferred ☐ AMA ☐ observation ☐ expired
Condition: ☐ stable ☐ fair ☐ good ☐ poor ☐ critical ☐ improved
Follow-up: ☐ ED ☐ PMD ☐ on-call ______ in ______ days
Instructions: ______
Rx: ______

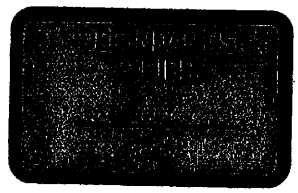
ATTENDING NOTE
☐ Resident/NP/PA note reviewed ☐ pt interviewed ☐ pt examined
Pertinent HPI: ______
My exam reveals: ______
☐ Labs reviewed ☐ X-rays reviewed
☐ I agree with above diagnosis ☐ I have reviewed the treatment plan / concur

______ Resident / NP / PA
[signature] MD / DO

☐ *See Addendum Sheet*

COOSA COUNTY SHERIFF'S DEPARTMENT
COOSA COUNTY LAW ENFORCEMENT CENTER
#1 SCHOOL STREET • P. O. BOX 279 • ROCKFORD, AL. 35136-0279
(256)377-4922 • (256-377-2211)
FAX (256) 377-2690

FAX COVER SHEET



TO: Dr Weaver

ATTN:

FROM: CCSO

REMARKS: Med list from Matt Hellyer from Cheaha Mental Health on Daniel Bryan Kelley

DATE 11/25/03

NUMBER OF PAGES 2

Tues. 11/25/03

Mr. Brian Kelley was evaluated by myself on 11/25/03. Complaints of Seizure d/o w/ episodic memory loss, Black outs? Needs evaluation by MD to r/o Seizure d/o

Hx of Prior Rx: Clonazepam 2mg Bid
Neurontin 300mg Tid
Zyprexa 5mg ÷ po qhs
Phenobarbitol 100mg Bid
Seroquel 200mg Tid

Hx of Bi-polar d/o, Can you assist this young man w/ Rx continuation.
Thank you for your assistance

I am not aware of any Allergies or possible side-effe

Matthew a. Holyn M.Ed

Chester MHC

Sylacauga

Cymbalta™
duloxetine HCl

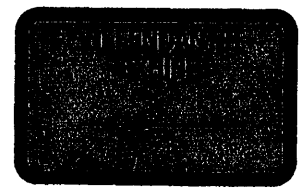
Walmart - D
Apothecary - Disconnected
Palace Drug - D
CVS - . .
Foodland - Lexapro 11/2#
~~Others~~ Nothing from anyone except you

Rite Aid - Lortab 7.5 - 11/10 #56 Dr James
Klonopin 2mg - 11/10 Dr James
Lortab 7.5 - 7/16 #6 Dr. Nekum
Vicoprofen 5/2004 Dr. Law
Lortab 5/2004 Dr Friday
Lortab 3/2004 Dr. Friday

Left a message | VM

TEMPLE MEDICAL CLINIC, P.C.
1120 Airport Dr., Suite 102
Alexander City, AL 35010
(256) 234-4295

NOVEMBER 22, 2004



CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Kelley
800 Pineview Lane
Sylacauga, AL 35150

Dear Mr. Kelley,

We find it necessary to inform you that as of November 22, 2004 the physicians of Temple Medical Clinic, P.C. will no longer be available for your medical needs. If you so desire, we will continue to provide emergency medical care and treatment for ongoing medical conditions for 30 days from receipt of this letter. At that time, however, our physician/patient relationship will end.

This should give you ample time to select another physician from the many competent practitioners in this area. You may contact Russell Medical Center Physician Referral at 329-7149, the County Medical Society, or the Alabama Medical Association for the name of physicians in your area or referral suggestions.

With your written consent, our office will transfer your medical records to the physician of your choice.

MAILED
NOV 24 2004

James P. Temple, M.D.

Timothy J. Corbin, M.D.

Vincent Law, M.D.

JAMES P. TEMPLE, M.D.
DEA # AT 0477946 LIC. # 1813
TIMOTHY J. CORBIN, M.D.
DEA # BC 3702186 LIC. # 18256
VINCENT LAW, M.D.
DEA # BL 5525297 LIC. # 21966
120 AIRPORT DRIVE, SUITE 102
ALEXANDER CITY, AL 35010
(256) 234-4295

NAME Daniel Brian Kelley AGE ____

ADDRESS _____ DATE 2-2-04

ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞

Due to the above named patients medical conditon, it is advised that he not return to reincarcination at Coosa County Jail. If he does, Coosa County Jail is responsible for anything thay may happen to this patient related to his condition.

Refill ____ times

☐ Label

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

NP 950657774

[redacted]